

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9-59

8424

1  
MAY 1960  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08404

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>3hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dawn Brigette Buckler</b>		4. DATE OF DEATH Month Day Year <b>July 3, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1960</b>
9. AGE (In years lost birthday) <b>5</b> yrs.		10. IF UNDER 1 YEAR <b>5</b> Months <b>2</b> Days	11. IF UNDER 24 HRS. <b>5</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Allen Buckler</b>		14. MOTHER'S MAIDEN NAME <b>Doris Jean Posey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive failure</b> DUE TO <b>7544</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial fibroclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 11, 1960</b> to <b>June 1960</b> , that (I) (we) last saw the deceased alive on <b>Feb 11, 1960</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Leon Barbue</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leon Barbue</b>		22d. ADDRESS <b>Mechanicsville Leonardtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		23d. LOCATION (City, town, or county) (State) <b>Morganza, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 6 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

2078254X18

10888

OFFICIAL STATE OF TEXAS

10888



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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 42 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08405											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b>						c. LENGTH OF STAY in 1b <b>Life</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>Rural Hollywood</b>					
3. NAME OF DECEASED (Type or print) <b>Charles Manley Clarke Jr.</b>						4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12, 1957</b>		9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Charles Manley Clarke</b>						14. MOTHER'S MAIDEN NAME <b>Jean Marie Edwards</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Charles M. Clarke</b> Address <b>Hollywood, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>929.8</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>IMMED</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off wall at Charles's Landing.</b>							
20c. TIME OF INJURY Month, Day, Year <b>7-23-60</b> Hour <b>7:00</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Charles's Landing</b>		20f. (City or town) <b>Hollywood</b> (County) <b>St. Mary's</b> (State) <b>MD</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W.D. Boyd</b>				EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>				DATE SIGNED <b>7-24-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or country) (State) <b>Hollywood, Maryland</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Maryland</b>						24a. REC'D BY REGISTRAR <b>JUL 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>			

08105

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Small Hollywood Little Hollywood

Charles Charles Charles

Small Hollywood Little Hollywood

Charles Charles Charles

Charles Charles Charles

Small Hollywood Little Hollywood

Charles Charles Charles

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL CERTIFICATION

Item 10-2260 0-8-60 ams											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08406											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park						c. LENGTH OF STAY in 1b 6 mos 25 dys X Lexington Park					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 343 Chinlee Drive						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Elwin Last CROCKER						4. DATE OF DEATH Month July Day 24 Year 19 60					
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 Dec 1959		9. AGE (In years last birthday) yrs. 6 Days 25		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) NAS., PaxRiv., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. CROCKER						14. MOTHER'S MAIDEN NAME Jean F. JONES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Father: R. E. CROCKER		Address 343 Chinlee Dr. LexPk., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION, due to tracheobronchial occlusion 922.0 DUE TO by aspirated gastric contents Immediate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -							
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hosp		20f. (City or town) -		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> George R Swan LT. George R. SWAN, MC, USNR Stahosp., Nas., PaxRiv., Md. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Wm. D. BOYD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-24-60 Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/27/60		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery				22d. LOCATION (City, town, or country) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR ADDRESS P.B. Robinson - Leonardtown, Md.						24a. REC'D BY REGISTRAR DATE AUG 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8425

STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08407

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>D. O. A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katharine</b> Middle <b>Elizabeth</b> Last <b>Duvall</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael F. Russell</b>				14. MOTHER'S MAIDEN NAME <b>Marcella Tyson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Edwin B. Russell</b>				Address <b>Avenue, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>6 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County) <b>19</b>		20h. (State) <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>7-24-19</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W H Patrick</b>				22b. DATE SIGNED <b>7-25-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>William H. Patrick M. D.</b>				22d. ADDRESS <b>Lexington Park, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey Inc.</b>				ADDRESS <b>Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

1  
8426

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08408

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Benjamin</b> Last <b>Ellis</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1911</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Ellis</b>		14. MOTHER'S MAIDEN NAME <b>Annie Knott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Agnes Ellis</b>		Address <b>Compton, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Cardio Vascular Disease</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>July 21, 1960</b> that (I) (we) last saw the deceased alive on <b>July 20, 1960</b> , and that death occurred at <b>4:38 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Boyd M. D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Leonardtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/23/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>JUL 25 '60</b>	
ADDRESS <b>Leonardtown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

08202

CERTIFICATE OF DEATH

8458



CHIEF

SECTION

LABORATORY

State Laboratory, Leominster, Mass.  
Date of Death: May 1, 1912  
Place of Death: Leominster, Mass.  
Cause of Death: ...  
Age: ...  
Sex: ...  
Color: ...  
Height: ...  
Weight: ...  
Build: ...  
Hair: ...  
Eyes: ...  
Skin: ...  
Signature: ...  
Official Seal: ...

8434

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pearl Love Fowler</b>		4. DATE OF DEATH Month Day Year <b>July 28 19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Love</b>		14. MOTHER'S MAIDEN NAME <b>Ada Holmes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>John A. Fowler - Mechanicsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular dis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH. <b>1 week</b> <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1948</b> to <b>July 28 1960</b> , that I last saw the deceased alive on <b>July 28 1960</b> and that death occurred at <b>St. Marys</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Roy Guyther</b>		DATE SIGNED <b>7/29/60</b>	
PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, MD</b>		ADDRESS (Street, city or town, state) <b>Mechanicsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/1/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson, Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1876		New York City	
Usual Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St		Teacher		Heart Disease		Jan 20 1921		Home	
Physician		Medical Examiner		Burial Place		Date of Burial		Place of Burial	
Dr. Smith		Dr. Jones		Cemetery		Jan 25 1921		Greenwood	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08410

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>47X-2</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <b>3408 25th Street S. E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Henry Gary</b>		4. DATE OF DEATH Month Day Year <b>July 24, 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1925</b>
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months Days <b>35</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	
11. BIRTHPLACE (State or foreign country) <b>Edgefield, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edgar Gary</b>		14. MOTHER'S MAIDEN NAME <b>? ? ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>WW 2</b>	
17. INFORMANT <b>?</b>		Address <b>?</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing chest injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>and accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7-24-60 4:00</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Run 35</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hollywood</b>		20f. (City or town) (County) (State) <b>Hollywood St Mary Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>7-24-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/28/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR <b>James C. Chemin</b>		ADDRESS <b>Arlington, Va.</b>	
24a. REC'D BY REGISTRAR <b>JUL 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

2605 S. Seminary Road /

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(1)

James C. ...  
Office of the ...  
Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

8436

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08411

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b>				c. LENGTH OF STAY IN 1b <b>18 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Ignatius</b> Last <b>Habig</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1882</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Damien Habig</b>				14. MOTHER'S MAIDEN NAME <b>Mary Stegmaier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>			
17. INFORMANT <b>Mary Viola Habig</b>				Address <b>Hollywood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peripheral vascular disease of lower extremities</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <b>June 30, 1960</b> to <b>July 2, 1960</b> , that (I) (we) lost saw the deceased alive on <b>July 2, 1960</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Julian S. Lane M. D.</b>				22b. DATE SIGNED <b>7/3/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Julian S. Lane M. D.</b>				22d. ADDRESS <b>Lexington Park, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR <b>DATE JUL 6 '60</b>			
ADDRESS <b>Leonardtwn, Maryland</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>			

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OFFICE OF DEATH

8436

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8437

## CERTIFICATE OF DEATH

08412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Daniel Ernest Lee</b>			4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1879</b>		9. AGE (In years last birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Daniel Lee</b>			14. MOTHER'S MAIDEN NAME <b>Zora Talton</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>J. Jerome Lee - Lexington Pk. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 9, 1960</b> to <b>July 11, 1960</b> , that I last saw the deceased alive on <b>July 11, 1960</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Wm. H. Patrick</b>		M.D. <b>Lexington Park Md.</b>		DATE SIGNED <b>7-12-60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Patrick, MD</b>		<b>Lexington Park, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6-13-77

PLACE OF DEATH

HOME

DATE OF DEATH

6-13-77

TIME

10:00 AM

CAUSE OF DEATH

HEART DISEASE

MYOCARDIAL INFARCTION

CHOLESTEROL

HYPERTENSION

DIABETES

SMOKING

OBESITY

AGE

65

SEX

MALE

RACE

WHITE

EDUCATION

HIGH SCHOOL

OCCUPATION

RETIRED

RELATIONSHIP

SPOUSE

DATE OF BIRTH

6-13-12

DATE OF DEATH

6-13-77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8427

08418

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loveville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Paul B Long</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1889</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Bernard Long</b>		14. MOTHER'S MAIDEN NAME <b>Molly Tippet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>6/26/18</b>		17. INFORMANT <b>Mrs Theodoras F. Long</b> Address <b>Loveville, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>464x</b> <b>Coronary Arteriosclerosis</b> DUE TO <b>The umbilic veinitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (his hospital) attended the deceased from <b>in March of 1960</b> to <b>March 1960</b> , that (I) (we) last saw the deceased alive on <b>March 1960</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael Barbarich</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Michael Barbarich M. D.</b>	
22d. ADDRESS <b>Leonardtwn</b> <b>Leonardtwn, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/11/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		23d. LOCATION (City, town, or county) (State) <b>Morganza, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 11 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

100-100

CERTIFICATE OF DEATH

2487

(M)

1. Name of deceased: *John J. Smith*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15, 1900*  
5. Date of death: *Dec 10, 1945*  
6. Place of death: *Home*  
7. Cause of death: *Heart disease*  
8. Signature of physician: *Dr. J. H. Jones*  
9. Signature of registrar: *John J. Smith*  
10. Signature of informant: *John J. Smith*

11. Name of informant: *John J. Smith*  
12. Address of informant: *123 Main St, New York, NY*  
13. Date of filing: *Dec 15, 1945*  
14. Registrar's signature: *John J. Smith*  
15. Registrar's title: *Registrar*  
16. Registrar's address: *123 Main St, New York, NY*  
17. Registrar's phone: *123-4567*  
18. Registrar's fax: *123-4567*  
19. Registrar's email: *john.j.smith@ny.gov*  
20. Registrar's website: *ny.gov*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

08414

8428

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. Mary's Hospital</b>		d. STREET ADDRESS <b>Wicomico</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>L.</b> Last <b>Long</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3 1880</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>St. Marys Co, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Long</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-5778</b>	
17. INFORMANT <b>Mrs. Eva M. Long</b>		Address <b>Charlotte Hall Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1958</b> to <b>July 1960</b> , that (I) (we) last saw the deceased alive on <b>16 July 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David L. Mossman</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>David L. Mossman</b>		22d. ADDRESS <b>Mechanicsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-19-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City, town, or county) (State) <b>Newport Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt &amp; Funeral Home, Waldorf, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

BP

1918

CERTIFICATE OF DEATH

8458

(M)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical report.]*

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 268 8-9-MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08415

8438

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NAS., Patuxent River</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Station Hospital</b>				e. STREET ADDRESS <b>Maryland</b>			
3. NAME OF DECEASED (Type or print) First <b>Angela</b> Middle <b>Rae</b> Last <b>OULMAN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 April 1960</b>		9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.A.</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gary Eugene OULMAN</b>				14. MOTHER'S MAIDEN NAME <b>Gay Jeannette SAGER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Father: Gary E. OULMAN, 48 Salamaua Court, Lexington Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Focal</b> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>155 hr.</b> <b>40 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>N.A.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N.A.</b>					
20c. TIME OF INJURY Month <b></b> Day <b>19</b> Year <b></b> Hour <b>N.A.</b> o. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N.A.</b>		20f. (City or town) <b>N.A.</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6 July 1960</b> to <b>12 July 1960</b> , that (I) (we) lost saw the deceased alive on <b>12 July 1960</b> , and that death occurred on <b>12:10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>D. G. Anderson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-12-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LT D. G. ANDERSON, MC, USN</b>				22d. ADDRESS <b>StaHosp., NAS., Patuxent River, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

9VVVVVVXVV

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08416

8429

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Monroe</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>5 dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		d. STREET ADDRESS <b>476 Emerson St.</b>	
3. NAME OF DECEASED (Type or print) <b>Harris Brooks Pettet</b>		4. DATE OF DEATH <b>July 3 19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/1881</b>
9. AGE (In years lost birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass blower</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glass</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mark Pettit</b>		14. MOTHER'S MAIDEN NAME <b>Ella Hann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>104 07 2803</b>	
17. INFORMANT <b>Adeline Whyte</b>		Address <b>996 Denise Rd. Rochester, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-29</b> , 19 <b>60</b> , to <b>7-3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7-3-60</b> , and that death occurred at <b>5:24 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park Twp. 7-3-60</b>	
PHYSICIAN'S NAME (Type) <b>W.H. PATRICK M.D.</b>		DATE SIGNED <b>LEXINGTON PARK, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rochester, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	





TO DELIVER BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
8439 08417														
1. PLACE OF DEATH a. COUNTY St. Mary's					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Compton					b. COUNTY St. Mary's									
c. LENGTH OF STAY IN 1b 2 hours					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown, Md.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last Joseph H. Price					4. DATE OF DEATH Month Day Year July 19 19 60									
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 1, 1927 32 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish washer in Restaurant					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Clements, Md.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME Alice Buchanan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. 2					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs. Alice Buchanan Leonardtown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Immed.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Went swimming in heavy winter clothes, Could not swim. had been drinking.									
20c. TIME OF INJURY Month, Day, Year Hour 8.30 p.m. 7/19/ 19 60					20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Breton Bay				
20f. (City or town) Compton, St. Mary's, Md.					20g. (County) St. Mary's					20h. (State) Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE W.D. Boyd										M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) William D. Boyd										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county) Leonardtown, Md.										DATE SIGNED 7/20/'60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF July 22, 1960					22c. NAME OF CEMETERY OR CREMATORY St. Aloysius				
22d. LOCATION (City, town, or country) Leonardtown, Maryland					24a. REC'D BY REGISTRAR JUL 22 '60					24b. REGISTRAR'S SIGNATURE Arthur L. Kraus				
23. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.														

14

1

William D. Ford

10-22-10

10-22-10

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8430

08418

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Bryantown</b>			
				d. STREET ADDRESS <b>08X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Susan</b> Last <b>Quade</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 13, 1925</b>	
9. AGE (In years lost birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Ashby Quade</b>				14. MOTHER'S MAIDEN NAME <b>Nellie E. Farrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mrs Nellie E. Quade Hughesville, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Cervix</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>171X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-4-1960</b> to <b>JUL 16, 1960</b> that (I) (we) last saw the deceased alive on <b>JUL 15, 1960</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon B. M. D.</b>				22b. DATE SIGNED <b>20 JUL 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leon Berbue M. D.</b>				22d. ADDRESS <b>Mechanicsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR <b>JUL 20 '60</b>			
ADDRESS <b>Leonardtwn, Maryland</b>				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

8440

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Park Hall</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>225 North Jackson</b>	
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Younger</b> Last <b>Roche</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary-Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Attorney</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Younger</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Clayton North</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-18-9059</b>	
17. INFORMANT <b>William W. Roche</b>		Address <b>225 N. Jackson St. Arlington</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7/9/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac H. Morris</b>		ADDRESS <b>Arlington Funeral Home 3901 N. Fairfax Drive</b>	
24a. REC'D BY REGISTRAR <b>DATE 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
HEALTH DEPT.

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1918"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
PLACE OF DEATH [Faint text, possibly "Home"]			
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]			
MANNER OF DEATH [Faint text, possibly "Natural"]			
SIGNATURE OF EXAMINER [Faint signature]			
DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1918"]			

This certificate is valid only when filed in the proper office and is subject to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1917, Chapter 200, and the Act of the General Assembly of the State of Maryland, passed at the Session of 1918, Chapter 100.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8431

## CERTIFICATE OF DEATH

08420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>California</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Estelle</b> Last <b>Sunderland</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/17/1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>16</b> Hours <b>00</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Tucker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia DeVaux</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>James C. Sunderland -California, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>60</b> to <b>July 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 12</b> , 19 <b>60</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Patrick</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Lexington Park, Md. 7/13/60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Patrick, MD</b>		<b>Lexington Park, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		ADDRESS <b>Jul 19 60</b>	
24a. REC'D BY REGISTRAR <b>Jul 19 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

CERTIFICATE OF DEATH

8421

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1900		Maryland		Baltimore		Heart Disease		1945		10:00 AM		St. Mary's Hospital		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment	
Teacher		Married		None		1944		1944		1944		1944		1944		1944		1944		1944		1944	
Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Heart Disease		1945		10:00 AM		St. Mary's Hospital		J. Doe, M.D.		J. Doe, M.D.		Heart Disease		1945		10:00 AM		St. Mary's Hospital		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment	
Teacher		Married		None		1944		1944		1944		Teacher		Married		None		1944		1944		1944	
Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Heart Disease		1945		10:00 AM		St. Mary's Hospital		J. Doe, M.D.		J. Doe, M.D.		Heart Disease		1945		10:00 AM		St. Mary's Hospital		J. Doe, M.D.		J. Doe, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8441

08421

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Avenue</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Clyde Utz</b>				4. DATE OF DEATH Month Day Year <b>July 6, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail carrier &amp; Trucker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Madison, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Nelson Utz</b>				14. MOTHER'S MAIDEN NAME <b>Annie Utz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 24 5561</b>		17. INFORMANT <b>Sally W. Utz</b>		Address <b>Avenue, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.4</b> IMMEDIATE CAUSE (a) <b>Acute dilatation of Heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12</b> 1960 to <b>July 6</b> 1960, that (I) (we) last saw the deceased alive on <b>July 5</b> 1960, and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles Greenwell</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>				22d. ADDRESS <b>Leonardtown, Maryland</b>			
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 9, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Madison Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 8 '60</b>	
				25b. REGISTRAR'S SIGNATURE			

(M)

X

1

MEDICAL CERTIFICATION

20

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>8442</div> <div>8442</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>																													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Saint Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - New Market, Md.</b> c. LENGTH OF STAY IN b <b>1 yr.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Maryland State Highway #5</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>U.S. Naval Air Station</b> d. STREET ADDRESS <b>Patuxent River, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mitchell Wayne WARD</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>11</b> Year <b>60</b>			<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>Caucasian</b>			<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>14 April 1940</b>			<b>9. AGE</b> (In years last birthday) <b>20</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Aviation Elec.</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Navy</b>						<b>11. BIRTHPLACE</b> (State or foreign country) <b>North Carolina</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>											
<b>13. FATHER'S NAME</b> <b>Archie Leon WARD</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Ruth (n) GORE</b>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 10-1-58 to 7-11-60</b>						<b>16. SOCIAL SECURITY NO.</b> <b>240-64-1318</b>						<b>17. INFORMANT</b> <b>U.S. Official Navy Records</b> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FRACTURED SKULL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>None</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in Private Automobile and was struck by on-coming truck.</b>																							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>1:15</b> <del>xxx</del> <b>7-11</b> <b>1960</b>						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Rt. 5, 1 mile So. New Market, St. Mary's, Md.</b>				<b>20f. (City or town) (County) (State)</b>																	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>WM. D. BOYD</b>						<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)						<b>DATE SIGNED</b> <b>7-11-60</b>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>						<b>22b. DATE THEREOF</b> <b>7/12/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Taber City, North Carolina</b>				<b>22d. LOCATION (City, town, or country) (State)</b>																	
<b>23. FUNERAL DIRECTOR</b> <b>P.B. Robinson - Leonardtown, Md.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>JUL 19 '60</b>						<b>24b. REGISTRAR'S SIGNATURE</b> 																	



06553

06553

State of Maryland

County of Prince George's

County of Prince George's

1. I, David M. Starnes

1 yr.

1. I, David M. Starnes

Prince George's River, Md.

Prince George's River, Md.

July 11, 1960

July 11, 1960

July 11, 1960

July 11, 1960

1. I, David M. Starnes

1. I, David M. Starnes

USA

North Carolina

U.S. Navy

U.S. Navy

with (n) CORN

with (n) CORN

For 10-1-58 to 9-1-60-00-1918 U.S. Official Records

EXTRACTED FROM

Name

Resident in Prince George's County and was struck by oncoming train.

1. I, David M. Starnes, 1 mile S.W. New Market, Md.

7-11-60

Prince George's River, Md.

July 11, 1960

U.S. Navy - Prince George's River, Md.